

**District of Columbia
Physician Assistant Delegation Agreement Form**

This document is to be filed with the Board of Medicine. A duplicate copy is to be kept on site at the physician assistant's primary place of practice. It is to be updated as necessary. The Delegation Agreement must be signed by the physician assistant and the supervising physician(s).

*Use Form A 2 to terminate the Delegation Agreement. (if there is a change in the physician assistant's employment or employment status)

*Use Form A 3 for the quarterly Physician Assistant practice advisory review

Physician Assistant

Name (first, middle initial, last) _____
DC License number _____

Primary Supervising Physician / Department Director

Name (first, middle initial, last) _____
DC License number _____

Location (of Practice)

1. Practice Name _____
Department _____
Address _____
Phone number _____

2. Name _____
Department _____
Address _____
Phone number _____

Delegation of Duties

The physician assistant is delegated to perform the following tasks and procedures that are within physician assistant's education and training and the supervising physician's scope of practice. Indicate those that are delegated to be performed in the above practice. If the physician assistant will provide patient care at sites other than the location address above please delineate.

Pronounce death of patients

(Subsection 4911.3, Chapter 49 PHYSICIAN ASSISTANTS of the District of Columbia Municipal Regulations- final rulemaking action February 8, 2013)

Physician assistant may pronounce death of patients Yes___ No___

Prescriptive Authority

Physician assistants may prescribe those drugs and devices delegated by the supervising physician. This includes non-scheduled and Schedule II-V medications. List the classes of medications the physician assistant may prescribe.

Controlled substances Yes ___ No___

Check schedules of medications:

- ___ Schedule II
- ___ Schedule III
- ___ Schedule IV
- ___ Schedule V

This delegation of prescriptive authority **DOES NOT** include the following medications:

Supervising Physician Availability

A supervising physician must be available in person or via electronic communications. Describe when and how a supervising physician is available to the physician assistant while the physician assistant is providing patient care. Describe situations when the physician assistant is caring for patients while the supervising physician is away from the site. For these situations delineate how a physician is available to supervise the physician assistant taking into account the skills and the experience of the physician assistant, and the acuity patient problems seen in the practice.

Quality Assurance

Subsection 4914.9 of the C, Chapter 49 PHYSICIAN ASSISTANTS of the District of Columbia Municipal Regulations- final rulemaking action February 8, 2013)

Each physician assistant and the supervising physician listed on this delegation agreement and/or another supervising must complete a practice advisory review on a quarterly basis and document the review on a form kept on file in a personnel file at the location in which the physician assistant practices.

Use form A 3 for the documentation of the quarterly review

☐ I understand the requirement for quarterly practice advisory review and agree to comply with the regulation.

Sign and date this form.

Physician Assistant

Date DC License number

Supervising Physician

Date DC License number

Physician Assistant Delegation Agreement Termination Form

Physician Assistant

DC License number_____

Name _____

DC License number_____

1. Practice Name _____

Department _____

Address _____

Phone number _____

2. Name _____

Department _____

Address _____

Phone number _____

[illegible]

Physician Assistant

Date

DC License number

Supervising Physician

Date _____

DC License number